JOHN ELLERY
H.M. SENIOR CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

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REPORT TO PREVENT FUTURE DEATH

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026)

1	**CORONER** I am John Ellery, H.M. Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
2	**DATE OF REPORT** 28 May 2026
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4	**THIS REPORT IS BEING SENT TO** **1.** The Chief Executive of Shrewsbury & Telford Hospital NHS Trust (SaTH) You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 July 2026. I, the coroner, may extend the period.
5	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary

6	**SUMMARY OF CORONER'S CONCERN** See paragraph 10 below
7	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	**INVESTIGATION and INQUEST** On 11 September 2025 I commenced an investigation into the death of Alex Alfred ROBINSON, aged 36 years *[Your summary must include the following details]* **The medical cause of death was** I (a) Suspension by Neck (b) (c) (d) II **How, when and where** On 10 September 2025 West Mercia Police were called to Church Lane, Little Wenlock, Telford following reports of an unresponsive male who had ligatured himself [redacted]. Sadly, the male was declared deceased at the scene. **Conclusion** Suicide
9	**CIRCUMSTANCES OF THE DEATH** See paragraph 10 below
10	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Alex Alfred Robinson was admitted to the Royal Shrewsbury Hospital (RSH) on the 8 September 2025 when he was seen in the same day emergency centre by the consultant on call. That consultant has made a statement and in paragraph 12 sets out his plan including "arrange review by mental health liaison team (MHLT). Following discussion, MHLT provided advice and a leaflet to be given to the patient as they are not available on site out of hours to review the patient physically". In a later statement (in paragraph 3) the consultant further states "I was not present at that moment when the resident doctor discussed with MHLT service, but she informed me that MHLT informed her they will not be available to see Mr Robinson at that time".

	Subsequent inquiry with MHLT stated clearly that Midlands Partnership Foundation Trust (MPFT) Mental Health Liaison Team at RSH is a 24/7 service, they had the usual night cover of cover of two staff on the 8/9 September 2025 and that no formal referral was ever received. This conflicting information represents a lost opportunity for Alex to have received appropriate care from MPFT which may have prevented Alex from killing himself on the 10 September 2025, but this cannot be known.
11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* 1. Partner of Alex 2. The Chief Executive, Midlands Partnership NHS Foundation Trust (MPFT) I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
9	**SIGNATURE**